Care in Mind

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated Care in Mind as good because:

- Therapies offered were in line with National Institute for Health and Care Excellence guidelines
- Intensive support was provided to the young people from the clinical team with weekly sessions with both their nurse and psychologist
- Policies and plans in place reflected least restrictive practice and clear processes were in place for staff to follow if there was incident
- Young people were actively involved in their care, documentation was appropriate and accessible to young people
- Feedback from young people and their parents was positive about the support and care provided by the clinical team
- There was excellent multidisciplinary working and information sharing for the benefit of young people
- Specific qualifications in child and adolescent mental health practice was available for staff to access
- The service operated a duty and on call nurse system with a clinical nurse specialist available at all times to offer advice and guidance to staff and to respond to incidents
- Records were current, detailed and regularly reviewed
- Regular supervision and meetings took place, staff felt very well supported and welcomed the development opportunities.

Summary of findings

Contents

Good

Care in Mind

Services we looked at

Specialist community mental health services for children and young people

Summary of this inspection

Background to Care in Mind

Care in Mind, established in 2011 and has been registered with CQC since 2012. The service provides community based care and treatment for young people aged 16 to 25 with complex mental health needs. The service is multidisciplinary and includes; a psychiatrist, five psychologists, four nurse consultants, a family therapist and art therapist.

Care in Mind assists young people in their discharge from hospital and other secure settings. The provision of treatment and care provided to young people includes those living with family or within other services. The majority of the young people supported by Care in Mind live within their residential homes. Young people primarily have their appointments with Care in Mind therapists and nurses at their head office in Stockport.

Support offered by the team includes, monitoring of mental state, therapeutic risk management, contributing to the care planning and review, advice, training and support to the residential staff who support the young people within their homes.

There was a registered manager in post.

Care in Mind is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Care in Mind's last inspection was on 21 January 2014. At the inspection, the service met all the standards inspected.

Our inspection team

Team leader: Sarah Heaton

The team that inspected the service comprised two CQC inspectors and a specialist advisor with experience of child and adolescent mental health services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- attended a presentation from the executive management team including an overview of the service and model of care provided;
- spoke to the registered manager and nominated individual for the service;
- spoke with six other staff including two nurse practitioners, two psychologists, the consultant psychiatrist and the risk and compliance manager;
- spoke with three young people who were currently being supported by the service and one young person who had previously been supported by the service;

Summary of this inspection

- spoke with five parents of young people currently supported by the service and one parent of a young person who had previously been supported by the service;
- reviewed seven care records;
- received feedback about the service from an independent advocate;
- attended and observed one multidisciplinary meeting;
- conducted a tour of the premises and the therapy rooms;
- looked at a range of policies, procedures and other documents relating to the running of the service including minutes of meetings and staff files.

What people who use the service say

Young people we spoke with told us that staff were reliable and had helped them to become more confident and positive.

Young people reported staff were interested in them, genuinely cared and had helped to deal with difficulties. All young people we spoke with reported knowing how to complain about the service and give feedback.

Young people felt truly involved in their care, planning and reviewing their support with their team.

Parents we spoke with told us the service respected the confidentiality of young people. Their relatives were over the age of 18 and did not want information sharing with parents, this request was honoured by the service.

Parents felt the clinical staff communicated well within the team and ensured an effective handover for consistency for their relative. Being involved in the care programme approach meetings was an area parents felt the service was good at. The care programme approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health needs.

Significant progress in relation to young people's mental health and forward planning for their children was very positive from parents' experiences in relation to other service providers their children had experienced.

Family members would have liked other ways of giving feedback about the service, not just via the care programme approach process.

Both young people and their families felt an area of improvement was the communication in relation to outcomes of complaints, updating in the investigation process and timeliness of communication.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Risk assessments were detailed and risk management plans and crisis plans were in place for young people
- The risk management policy included clear flow charts for staff to follow in how to respond to a variety of incidents including overdose and ligatures
- Sickness levels were low in the team and there were no vacancies
- Staff received mandatory training including basic life support, health and safety, fire safety, food hygiene, infection control, manual handling, lone working, safeguarding children and vulnerable adults
- Staff had a good understanding of safeguarding, what constituted a safeguarding concern and how to respond
- Detailed care plans were in place in relation to young people prescribed medicines with specific monitoring requirements
- Young person friendly risk assessments were in place in addition to the full risk assessment called “my star my risk”, these documents were shorter and more meaningful to the young person
- Caseloads were manageable to allow for intensive support for young people.

However:

- One file had a crisis plan in place but not a risk assessment
- The lone worker policy did not have a consistent process for staff to follow if lone working
- Physical health monitoring records were not in the files at head office for all young people.

Are services effective?

Good

We rated effective as good because:

- All care records reviewed had comprehensive assessments in place. Care plans were person centred and young people rated their progress by use of the recovery star
- Care programme approach review meetings were based on the recovery star. Young people were fully involved in this process
- There was a prepared letter in each young person’s file with their mental health history, current challenges and how best to support them. Residential staff took the letter to accident and

Summary of this inspection

emergency if young people had self-harmed to the level they required hospital treatment. The letter avoided the young person having to talk through their circumstances to a variety of professionals and reduced their anxiety
- A young person who had previously accessed the service had been involved in reviewing the documentation
- Therapies provided were in line with National Institute for Health and Care Excellence guidance
- Staff received regular supervision and professional development review
- There was excellent multidisciplinary working and information sharing
- All staff had completed training in the Mental Capacity Act and Deprivation of Liberty safeguards (DOLs).
- Staff were knowledgeable on the Mental Health Act (MHA) and adhered to all requirements for young people on a Community Treatment Order.

However:

- Staff had not received training on the MHA and the changes in the revised code of practice.

Are services caring?

Good

We rated caring as good because:

- Young people reported the clinicians were supportive, listened and seemed genuinely interested in them
- Young people told us staff had helped them to deal with their difficulties and past problems and had helped them to move on and have a plan for the future
- Parents told us that staff respected the young person's right to confidentiality, their children were over the age of 18 and did not want their information sharing with their parents, and staff respected this. Parents reported their relatives had progressed and made significant improvements since receiving support from the service
- Staff spoke positively about young people and the progress they had made and truly enjoyed supporting the group of young people. The senior managers also knew who the service supported, their background and complexities and how to respond when providing support and guidance via the on call (a phone that nurse consultants carry out of office hours for staff to ring for advice, guidance and response to incidents)
- Young people were actively involved in their care and care planning process. Care plans were individualised and young person friendly

Summary of this inspection

- Young people rated their progress in relation to the recovery star in preparation of their reviews and core group meetings
- A young person who had previously received support from the service had been involved in completing audits of the residential services. Young people were also involved in reviewing the policies and had recently reviewed the care plan documentation to ensure it was young person friendly
- Young people had been involved in recruiting staff and facilitating training.

However:

- The information for young people regarding the therapies provided by the clinicians was not young person friendly and contained many words.

Are services responsive?

Good

We rated responsive as good because:

- Staff discussed new referrals within the weekly managers' meetings
- Clinicians attended the ward rounds and meetings with young people whilst in hospital to build the therapeutic relationship and plan the gradual transition from hospital to support from Care in Mind
- Discharge from the service was planned. Prior to discharge, the named nurse liaised with other professionals involved including general practitioners, ensured medication arrangements were in place and reviewed the young person's progress and documentation
- Records showed staff were creative with the engagement with young people including changing times of sessions and home visits for those young people struggling with engagement
- Information available for young people included; how to make our services safe, a guide to attachment and safeguarding information, all were young person friendly
- Staff had supported young people to access groups or additional support when identified to explore their sexuality and diversity
- Young people we spoke with were aware of how to make a complaint
- The service had received several cards and letters from young people they had supported, thanking them for the support provided and the progress they had made.

However:

Summary of this inspection

- The complaints log used did not record the actions taken and outcome of the complaint and did not use a reference for the complaint.

Are services well-led?

Good

We rated well-led as good because:

- Staff reported that the senior managers were approachable and due to the small size of the team, suggestions could be implemented quickly
- Clinical staff received mandatory training and role specific training and regular clinical and managerial supervision
- Staff contributed to internal audits including documentation and best practice
- The risk and compliance manager had completed a supervision survey with staff. Themes from the survey showed managers were approachable, knowledgeable and experienced
- Progress had been made in the corporate risk register from the initial information provided by the service to the time of inspection
- The organisation understood the fit and proper person requirement and there was a policy in place
- Sickness levels were low at 1.5%. There were no vacancies within the team
- The organisation had enabled staff to have access to a whistleblowing helpline, which was available anytime
- Staff reported managers were approachable and felt able to raise concerns with them, they reported being listened to and valued
- Managers were aware of the duty of candour and were able to give examples of occasions where this applied. Records showed staff had given the apology to the young person.

However:

- There were several meetings taking place with the same agenda, lessons learnt was not an agenda item, any learning was shared informally
- Managers had not received training in relation to leadership and management, they utilised their skills and knowledge they had developed within their career
- The organisational policy requirement of completing the fit and proper person declaration document annually was not taking place.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The service had one young person on a Community Treatment Order (CTO) at the time of inspection. A CTO is supervised treatment when patients leave hospital for their mental health needs. Staff had a good understanding of their role in relation to CTO, including explaining the rights with young people and ensuring they had access to advocacy. We reviewed the file, all CTO paperwork was in place, and there was evidence of clinical nurse specialists explaining the rights with the young person at admission and a month afterwards.

The service had a process for management of CTO, which was a flow chart showing the responsible clinician role moves to the psychiatrist from Care in Mind from the consultant at hospital. There was a service level agreement in place with a local mental health hospital to complete all MHA administration tasks. There were also arrangements for young person's recall to the local mental health hospital if needed. The service had a Community Treatment Orders policy dated April 2016, which referred to the revised code of practice and reference guide to the MHA 1983. The service also had a Mental Health Act 1983: information policy dated April 2016 stating that from September 2016 the Mental Health Act training will be a mandatory course. At the time of inspection, clinical staff were expected to update their own knowledge in relation to the MHA and did not access MHA training via the service.

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy on Deprivation of Liberty Safeguards (DoLS) dated December 2015. Managers revised the policy during our inspection to ensure that the age of eligibility of DoLs was correct, at 18 years.

Staff received training in Mental Capacity Act (MCA) and DoLS with 100% attendance, staff reported the training was very useful and enhanced their knowledge of the legislation.

Staff had a good understanding of MCA and DoLS. Clinicians were responsible for the consideration of capacity document, which they completed as part of the assessment process. The document included young people's capacity, which was decision specific and included the young person's capacity in relation to information sharing. There was completed consideration of capacity documents in all of the files we reviewed.

Specialist community mental health services for children and young people

Good

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are specialist community mental health services for children and young people safe?

Good

Safe and clean environment

Care in Mind rented office and therapy rooms space in a unit on an industrial estate. The service was in the process of buying a property, which would better suit the needs of the service and young people accessing the service.

Currently the facilities available were a meeting room and two therapy rooms. One of the therapy rooms was downstairs and accessible for people with mobility difficulties.

Staff did not use alarms within the service. However, all young people arriving for therapy appointments were escorted by their support staff who would wait outside of the room for them. If there was a difficult incident staff could call for assistance. There had been no incidents within the service.

The service did not have a clinic room and if physical health monitoring was required this would take place in the residential services.

All areas were clean and welcoming with comfortable furnishing and accessories.

Cleaning of the premises was the responsibility of the building owners; we observed cleaning taking place during the inspection.

There were health and safety records available for the building which we viewed which included; health and safety contingency plan, pregnant workers risk assessment, health and safety and fire risk assessment for the building.

Safe staffing

The service had 12 clinicians and a service director and clinical services manager who were qualified clinical nurse specialists. The 12 clinicians were: a consultant child and adolescent and mental health(CAMHS) psychiatrist, currently on consultancy one day a week, however, they will be joining the team full time in May 2016. There were four clinical nurse specialists, a part time family therapist and five clinical psychologists including one lead who had managerial responsibility too. Also, an art therapist, who was currently on consultancy and will be joining the team permanently in late April 2016.

Sickness levels were low at 1.5% from 1January 2015 to 31 December 2015. There were no vacancies within the team.

The clinical services manager used a scoping tool to calculate the staffing levels, incorporating the time allocated to each young person for weekly interventions, attendance at monthly core group and multidisciplinary team MDT meetings and three monthly care programme approach meetings. Included in the scoping was time for writing up sessions and supporting staff and young people in debriefs.

The clinical nurse specialists operated an out of hours on call system for advice and support to staff. They also conducted mental state assessments out of hours if there was a concern about a young person and would offer support post incident. This included guidance on monitoring the young person and conducting a post incident debrief for both staff and the young person.

Specialist community mental health services for children and young people

Good

The average caseload for full time clinical nurse specialists was nine young people to allow for the intensive support provided. Managers reviewed caseloads with staff within supervision.

There was a duty nurse on every day from Monday to Friday in office hours to provide advice and guidance to staff and to respond to incidents, they would go out to assess individuals in the service who has become unsettled and complete the debrief post incident. Outside of office hours staff used the on call service(a phone that nurse consultants carry out of office hours for staff to ring for advice, guidance and response to incidents).

The service did not use any bank or agency staff, they acknowledged that central to the service was therapeutic relationships with young people which could not be achieved if there were frequent changes of staff.

Although the consultant psychiatrist was based within the team one day a week, up until recently there was an additional part time consultant psychiatrist within the team. The current part time psychiatrist was contactable outside of their allocated time to the service to provide advice and input and would complete visits out of hours if needed. When on leave the CEO, who is a consultant psychiatrist, would provide cover.

All clinicians attended an annual mandatory training day, which includes health and safety, information governance, fire safety awareness, infection control, food hygiene, manual handling, basic life support including CPR, safeguarding vulnerable adults, safeguarding children, complaints and conflict management and lone working. Nine out of 12 staff had attended this, which equates to 75%. Other staff had dates to attend the training.

Assessing and managing risk to patients and staff

We reviewed seven care records. All care records were completed to a high standard. Six records had a Salford tool for assessment of risk (STAR) risk assessment in place, which staff had reviewed, and were current. In addition, there were risk management plans in place with clear actions for staff to follow if the risk presents. Young person friendly risk assessments were in place in addition to the STAR called “my star my risk”, these documents were shorter and more meaningful to the young person. Young people were involved in monthly core group meetings with their named nurse, psychologist and staff from their residential service. Within the meeting, people present reviewed the risk assessment. Minutes of the meeting were stored within young people’s care records. Crisis management plans were in place for young people where their circumstances warranted.

Detailed physical health care plans were in place, which included checks that staff needed to complete prior to commencing antipsychotic medication. The advice included cross referencing to the electrocardiogram(ECG) results and health and weight records which were not stored within three of the seven records we reviewed at head office, managers told us they were stored locally within the residential services.

Young people referred to the service are usually in hospital prior to being accepted by Care in Mind; two clinical staff assessed the young person and will attended ward rounds and to build a therapeutic relationship with the young person whilst they are in hospital prior to discharge.

Staff had received training in safeguarding adults and child protection: 67% of clinical staff had attended safeguarding training at level five, which was good practice. Staff we spoke to had a good understanding of safeguarding and child protection. They told us how they would respond to young people’s disclosures or concerning information. The registered manager was the safeguarding lead within the team. They accessed local safeguarding meetings. The safeguarding children policy, dated July 2015, provided a clear step by step guide of how to respond to allegations of abuse.

There was a lone working policy in place dated October 2015, this policy highlighted hazards of lone working and had supervision as a measure to reduce the risk of lone working. The policy stated that staff needed to “regularly check in with their line manager”. This was open to interpretation and did not provide staff with a consistent approach to lone working to ensure their safety. Staff we spoke with reported that the residential staff escorted the majority of young people to their therapy sessions. There was one young person the team supported in their family home. We highlighted this to managers during the inspection and they reviewed the policy. The new policy dated April 2016 stated that all lone workers would have a risk assessment conducted, the introduction of a log to highlight potential risks and whereabouts of staff and staff to ring in at 5pm if working beyond 5pm. Then ring in to say they were safe and had finished work.

Specialist community mental health services for children and young people

Good

Track record on safety

There were no serious incidents for this service.

Several incidents involving young people self-harming took place within the residential services and residential staff completed the incidents reports. Following incidents, staff and the young person received a debrief from Care in Mind staff and reflective practice took place. The debriefs with the young people focused on a restorative approach, including what happened, what had happened since, who had been affected and what needed to happen next. There was a duty nurse each day and a nurse on call in an evening and a weekend. Nurses on duty or on call could respond to incidents, offer post incident support and guidance to staff.

Reporting incidents and learning from when things go wrong

Staff we spoke to were aware of what constituted an incident and how to report an incident, however there were no recorded incidents for this service. The service had a risk management policy dated August 2015 with clear flow charts of how staff should respond if a young person overdosed or self-harmed in the form of cutting, ingesting, head-banging and use of a ligature.

Managers were aware of the duty of candour and were able to give examples where this applied across other parts of the organisation. Records showed staff had given the apology to the young person. There were no incidents within Care in Mind, which met the requirements of duty of candour.

Debriefs were recorded and group reflective practice sessions were held for staff teams where they could discuss challenges and situations they found difficult, this was explored with multidisciplinary guidance and alternative approaches were discussed.

There was an agenda item of risk management on the monthly governance meetings where they could discuss incidents and accidents. Staff felt very supported by the organisation and their colleagues.

Are specialist community mental health services for children and young people effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed seven care records. All care records reviewed had comprehensive assessments in place. Care plans were person centred and young people rated their progress by use of the recovery star. Young people completed the recovery star at the point of joining the service and reviewed the star prior to each care programme approach (CPA) meeting. Young people reviewed the recovery star in conjunction with their care team including clinical nurse specialist and clinical psychologist in preparation for their CPA. Within the CPA meeting, this focused on the areas of the recovery star and discussed strategies for young people to progress in their recovery.

Care plans showed evidence of young people's involvement in the creation and were goal focused. All care plans reviewed were up to date. Records showed staff were proactive at involving young people in their care and planning for the future. A young person who had previously accessed the service had been involved in reviewing the care plan documentation. This resulted in the documentation being more meaningful and accessible for young people.

An area of good practice was a prepared letter in each young person's file with their mental health history, current challenges and how best to support them. Residential staff took the letter to accident and emergency if young people had self-harmed to the level they required hospital treatment. The letter avoided the young person having to talk through their circumstances to a variety of professionals and reduced their anxiety.

Each file reviewed contained a 'case overview' document with important details including legal status, brief history, triggers, crisis management plan and current medication. This provided staff, particularly if new to the service, with a helpful summary of a young person.

Medication care plans were in place and young people had detailed physical health care plans where their circumstances warranted. In one file, this included a checklist for staff to follow in relation to physical health prior to the commencement of anti-psychotic medication.

Specialist community mental health services for children and young people

Good

There were cross references to physical health monitoring including weight recording for a young person. This was not stored in the file at the head office, however, information was held within the residential service. It is important for clinical staff to have access to this information, as they are responsible for prescribing medication and monitoring their treatment. We highlighted this to managers at the time of the inspection and this has since been rectified and copies added to the file. Two other files showed evidence of electrocardiogram (ECG) results and staff taking regular blood samples for weekly monitoring. A young person had a detailed management plan in place 'titration of clozapine' including clear actions for staff to follow and how to monitor side effects.

Records were paper records and the file stored at the head office had all of the content of the therapy sessions in. These were stored safely within the office in a locked filing cabinet. The spine of the file had the initial and reference number of the young person for confidentiality.

Best practice in treatment and care

Staff we interviewed had knowledge of good practice including National Institute for Health and Care Excellence (NICE) guidance. They gave examples of therapies provided and monitoring completed in line with NICE guidance.

NICE guidelines [CG155] Psychosis and schizophrenia in children and young people: Recognition and management Published date: January 2013, suggests the offer of family intervention to aid recovery, which the service provided. The guidance also recommends the use of cognitive behavioural therapy and art therapy, both of which the service provided. The guidance also advises that staff should complete the baseline investigations including weight and height and the completion of an ECG, which records showed, were taking place.

NICE guidelines [CG78] Borderline personality disorder: recognition and management Published date: January 2009 advises that young people should have a multidisciplinary care plan involving families; all care plans reviewed were multidisciplinary and reviewed with the CPA and core groups with attendance from a variety of disciplines. The structured clinical management approach of the service complied with the guidance in relation to managing endings and supporting transitions for young people.

Staff supported young people to have the annual physical health care check completed at their GPs and provided a summary of the appointment in the notes. The service was aware that they did not have the copies of the health checks in the files and were planning how to achieve this.

Clinical nurse specialists had an area of specialism to lead on including training, attending events and participating in audits. The specialisms included physical health, medication, care plans, safeguarding, research and young people participation. Since the risk and compliance manager joined the service in September 2015, they had conducted several internal audits including incident audits and an audit of British National Formulary (BNF) limit prescribing for antipsychotic medicines, which showed the young people were not prescribed medication above BNF limits. Audit and compliance meetings took place with agenda items including risk management, human resources and staffing, user and carer experience. There was an antipsychotic prescribing audit tool in place as a checklist for prescribers. This included if there was an ECG on file and a care plan for antipsychotic medication and blood results in the file.

Skilled staff to deliver care

The service was multidisciplinary and included a psychiatrist, five psychologists, four clinical nurse specialists, a family therapist and an art therapist. Two of the staff had completed the BSc(Hons) degree and one of the staff had completed the graduate diploma in child and adolescent mental health practice at the university of central Lancashire.

Upon joining the organisation all staff received and completed an induction workbook which included understanding the role of CQC, risk management, safeguarding children, safeguarding adults, boundary see saw model, defensible documentation, information sharing, mental capacity and Deprivation of Liberty Safeguards and a personal reflection.

The service had commissioned a training course in responding to behaviour that challenges called prevention, protection and restoring. The course covered six topics; stages of incident, primary prevention, secondary prevention, behaviour, self-protection and restoration phase. The course focuses on preventing incidents from occurring, exploring triggers for behaviour, cultural awareness and de-escalation.

Specialist community mental health services for children and young people

Good

Regular professional development events took place, topics included staff support, and mentalisation based therapy. Staff could also identify learning events to attend, which the service supported; a staff member was due to attend an event on attachment. Attachment includes relationships with children, their parents, carers, and the impact on young people if there were difficulties with the relationship.

Additional courses provided by the service included the boundary see saw model, which 67% of clinical staff had attended, recovery star with 75% of clinical staff having attended, structured clinical management with 83% clinical staff attendance and the safehomes model with 100% attendance. These are models of care and intervention that the service followed. The safehomes model was adapted from the safe wards model used in mental health inpatient services.

The supervision policy, dated March 2016 stated that staff should receive a minimum of 60 minutes of supervision every month. We reviewed four staff files, which showed staff were receiving regular supervision and had all completed their professional development review.

The service presentation explained how they managed poor staff performance including increased supervision and monitoring however, there were no staff within the clinical team being performance managed at the time of inspection.

Multidisciplinary and inter-agency team work

Clinical governance meetings took place monthly and agenda items included risk management, HR / staffing, user and carer experience and participation, education and training, clinical effectiveness and research, regulation and compliance and information governance and IT. All clinical staff were invited to these meeting however they were business focussed and the first clinical team meeting took place during the inspection on 13 April 2016. The meetings discussed how to use the meetings, frequency, co-working, outcome measures, young people engagement and reflective practice. We observed the meeting and felt there was excellent collaborative working with mutual respect and an emphasis on practitioners taking an active role.

Clinical nurse specialists provided the out of hours on call service and the duty service. If a young person was involved in an incident the clinical nurse on duty or on call would respond and would complete a debrief following the incident. Post debrief the nurse would communicate to the care team the event and outcome to ensure this could be explored within their sessions.

When new referrals had been assessed for the service and accepted the clinicians would attend the ward rounds if the young person was in hospital to build links with the other professionals involved and build a professional relationship with the young person.

Adherence to the MHA and the MHA Code of Practice

The service did not offer training on the Mental Health Act (MHA) specifically for clinicians, however a brief overview and jargon buster was included in the induction training. We reviewed a power point presentation regarding the MHA, which the service was going to provide to staff. Staff we spoke with had a good understanding of the MHA and their role in relation to the Act, including reading rights to young people who were on a Community Treatment Order. Staff had access to the MHA Code of Practice 2015 and the easy read version for use with young people. However, they had not received training on the revised code of practice.

The service had one young person on a Community Treatment Order (CTO) at the time of inspection. A CTO is a legal order. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community. Staff had a good understanding of their role in relation to CTO, including reading the rights with young people and ensuring they had access to advocacy. We reviewed the file, all CTO paperwork was in place, and there was evidence of clinical nurse specialists reading the rights with the young person at admission and a month afterwards. There was a recording rights policy in place, dated April 2016.

The service had a process for management of CTO, which was a flow chart showing the responsible clinician role moves to the psychiatrist from Care in Mind from the consultant at hospital. There was a service level agreement in place with a local mental health hospital to complete all MHA administration tasks. There were also arrangements for young person's recall to the local mental health hospital if needed. The service had a Community Treatment Orders policy dated April 2016, which referred to the revised code of practice and reference guide to the MHA 1983. The service also had a Mental Health Act 1983: information

Specialist community mental health services for children and young people

Good

policy dated April 2016 stating that from September 2016 the Mental Health Act training will be a mandatory course. At the time of inspection, clinical staff were expected to keep their own knowledge in relation to the MHA current.

Young people accessed the independent mental health advocacy service in their local area.

All records we reviewed had a 'consideration for capacity' document completed.

Good practice in applying the MCA

All staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff reported the training was very useful and enhanced their knowledge of the legislation.

Staff we spoke with had a good understanding of MCA and DoLS. Clinicians were responsible for the consideration of capacity document, which they completed as part of the assessment process. The document included young people's capacity, which was decision specific and included the young person's capacity in relation to information sharing. There was completed consideration of capacity documents in all of the files we reviewed.

The DoLS policy was dated December 2015. Part of the policy related to DoLS applications for young people under 18, which was confusing and incorrect. We highlighted this issue to the managers, and they advised this was added because of one young person where they submitted a DoLS application prior to their 18 birthday. The policy was updated during the inspection and amended to reflect that DoLS only apply to people over the age of 18, the updated policy was dated April 2016.

Staff were aware of Gillick competence and young people's capacity to consent. Staff respected the view of young people, especially when 18 years or over if they had expressed that they did not want information sharing with their parents regarding their care and treatment. Parents we spoke with confirmed this.

Are specialist community mental health services for children and young people caring?

Good

Kindness, dignity, respect and support

We spoke with three young people currently receiving support from the organisation and one young person who previously received support. Young people reported the clinicians were supportive, listened and seemed genuinely interested in them. Young people told us staff had helped them to deal with their difficulties and past problems and had helped them to move on and have a plan for the future.

Parents we spoke to had children who were over the age of 18, they told us that staff respected the young person's right to confidentiality. If the young people did not want their information sharing with their parents, staff respected this. Parents reported their relatives had progressed and made significant improvements since receiving support from the service.

Staff we spoke with knew the young people well, were aware of individual needs and stages of their recovery. Staff spoke positively about young people and the progress they had made and truly enjoyed supporting the group of young people. The senior managers also knew who the service supported, their background and complexities and how to respond when providing support and guidance via the on call. Minutes also showed updates of young people's progress, plans for the future and challenges faced. Staff shared knowledge and skills to further improve the support provided to young people.

The involvement of people in the care they receive

Young people were actively involved in their care and care planning process. Care plans were individualised and young person friendly. Young people rated their progress in relation to the recovery star in preparation of their reviews and core group meetings. Young people reported their experience of transition into the service was the service provided a detailed process, which they understood. Young people reported receiving copies of their care plans. Access to advocacy was happening.

Specialist community mental health services for children and young people

Good

A young person who had previously received support from the service had been involved in completing audits of the residential services. Young people were also involved in reviewing the policies and had recently reviewed the care plan documentation to ensure it was young person friendly. Young people had been involved in the creation of welcome guides for the residential services, which were colourful, accessible and young person friendly with the use of questions and answers and photographs. However, the leaflet in relation to therapies provided to young people was not young person friendly, with lots of text.

Family members attended review meetings, felt involved in the process, and were able to share their views.

A young person had been involved in training staff, sharing their experiences and background and the progress that they had made.

Young people had been involved in interviewing new staff, they chose questions that they wanted to ask candidates and gave feedback to the panel at the end of the interview to inform the decision making process.

Young people were involved in the review of their care plans and risk assessments. They received de briefs following incidents with the aim of a greater understanding of triggers, reasons for behaviour, impact on other people and changes to reduce the likelihood of reoccurrence.

The service was in the process of establishing a participation group for young people who were currently or had historically received support from the service to be involved in the running of the organisation. Staff had promoted the group to the young people and had set the date for their first partnership meeting.

An annual satisfaction survey had been sent out to all young people supported by the service in early 2016, the survey topics included; home, therapies, do you understand the meetings, do you know how to complain and general feedback. Young people had returned nine surveys. Very positive feedback was noted in relation to therapies. Young people reported they knew how to complain, understood their care plans and were involved in their care. Three surveys noted that the young people did not find their meetings useful.

Are specialist community mental health services for children and young people responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Staff discussed new referrals within the weekly managers meetings. Once a referral had been received a pre-assessment took place to determine the appropriateness of the referral. If the team felt it was an appropriate referral, two clinical staff would visit the young person to complete an assessment of their needs. Usually the referrals were for young people who were in hospital and the clinicians attended the ward rounds and meetings with young people whilst in hospital to build the therapeutic relationship and plan the gradual transition. The admission, transfers and discharges policy, dated September 2015, advised that the service does not take emergency referrals. The service did not have any exclusion criteria, staff assessed each referral and the team made a decision as to whether they had the skills to meet referrals needs.

Discharge from the service was planned. Prior to discharge, the named nurse liaised with other professionals involved including general practitioners, ensured medication arrangements were in place and reviewed the young person's progress and documentation. One young person we spoke with was aware they were nearing their discharge and told us their nurse regularly reviewed the plans with them.

Records showed staff were creative with the engagement with young people including changing times of sessions and home visits for those young people struggling with engagement.

The structured clinical model that the staff followed suggested that sessions are the same time and day each week to provide consistency and clear boundaries for young people. The service model was that young people had weekly sessions with both their nurse and therapist.

The facilities promote recovery, comfort, dignity and confidentiality

Specialist community mental health services for children and young people

Good

Young people visited the head office or another satellite location for their one to one sessions and therapy sessions. Within the main head office, there were three therapy rooms available for use, two of which were on the ground floor and accessible for people with mobility difficulties. Staff did not dispense medication from the premises or complete physical health checks, therefore there was no clinic room.

Therapy rooms were modern with neutral decoration, well maintained and had relaxed seating. However, there was no waiting room for the service and young people would need to wait in the main buildings reception until their therapist came to collect them for the appointment.

Information available for young people included; how to make our services safe, a guide to attachment and safeguarding information, all were young person friendly. Other information included; art therapy, psychological therapy, how to complain, your health care records and access to advocacy. However, the information in relation to therapies was not young person friendly, with lots of words in the booklet.

Young people within the residential services travelled with support to the two Care in Mind locations for their therapy and one to one sessions, to have a clear distinction between home and therapy space. The journey could be quite long due to the location of the services and the organisation was in the process of identifying new premises that they could develop to the needs of their service. If the organisation expanded into other areas, the plan was to identify further hub or satellite locations to reduce travel time and offer more regional services. If the need determined, staff could provide sessions within people's own homes and this was occurring with one young person who lived with their family.

Meeting the needs of all people who use the service

Although there was not information available in other languages, staff told us they could access translation services if required for young people. Records showed that staff used interpretation services when young people whose family members had limited understanding of English, as it was not their first language were attending meetings.

Staff had supported young people to access groups or additional support when identified to explore their sexuality and diversity.

The service had created accessible care plans for young people with limited literacy skills including the use of symbols.

The service identified religious needs for young people and the residential staff had supported young people to practice their faith by supporting them to attend church.

Listening to and learning from concerns and complaints

The service had not had any complaints within the last 12 months. Complaints received had been in relation to their residential services.

Young people we spoke with were aware of how to make a complaint. They reported they had been involved in making suggestions regarding the residential services.

The therapies leaflet had how to complain information on the back and there was additional information available to young people on how to complain and provide feedback.

The complaints policy, dated January 2015 advised that all complaints received "would be recorded on the complaint recording spreadsheet". We reviewed the complaints file, which had complaints information stored within it, and responses made from managers in relation to complaints. A recently introduced complaints log was in place however the complaints did not have reference numbers on, staff had not dated some of the letters sent, and the log did not capture the actions taken and the outcome of the complaint.

The service had received several cards and letters from young people they had supported, thanking them for the support provided and the progress they had made.

Are specialist community mental health services for children and young people well-led?

Good

Vision and values

The presentation at the beginning of the inspection was facilitated by the executive team, each presenting a separate topic including, overview of the service, therapeutic approaches and models of care, involving

young people in their care and the organisation, pathways into the service, quality and compliance, collaborative risk assessment and management and learning and development.

The mission statement of the organisation included to provide "excellent, innovative and collaborative care". Staff we spoke with were passionate about the young people supported, records reviewed and the multidisciplinary meeting we observed showed excellent collaboration and support with the aim of achieving positive outcomes for complex young people. One young person and a parent of a young person previously supported by the organisation confirmed this was achievable; they had attended university and were living independently.

Staff reported that the senior managers were approachable and due to the size of the team, changes could happen quickly. The senior managers and clinicians attended the monthly clinical governance meetings where there was a flow of information and staff felt that their views were valued and made meaningful contributions.

Good governance

Staff contributed to internal audits including documentation and best practice. The risk and compliance manager had completed a supervision survey with staff earlier in 2016; there were 10 completed surveys. Themes included managers were approachable, knowledgeable and experienced.

Several meetings took place including monthly clinical governance meetings, fortnightly managers meetings, monthly audit meetings, monthly residential managers meetings, recently introduced monthly medicines management meetings, recently introduced monthly nurse meetings and we observed the first clinical team meeting which was multidisciplinary. The majority of the meetings had the same agenda items. When exploring lessons learned with staff they advised it was shared informally as they are a small team and possibly would be shared via the clinical governance meetings however, the minutes we reviewed did not have lessons learnt as an agenda item.

There were eight non-clinical staff providing assistance with operations, human resources, finance, administration, development and risk and compliance.

The corporate risk register had four open risks relating to the clinical team in the information submitted prior to the inspection. Risks related to information governance, recruitment and human resources. When we reviewed the risk register at the inspection the four risks had been closed and actions achieved including recruiting additional staff and changing the recruitment process and independent advice and consultancy. The actions from the risk register were discussed at the fortnightly managers' meetings and staff could discuss items to be added to the risk register within the managers' meeting.

Fit and Proper Person Requirement

The Fit and Proper Person Requirement (FPPR) is a regulation of the Health and Social Care Act 2008(Regulated activities) Regulations 2014, which applies to all independent health providers from April 2015. Regulation 5 says that individuals, who have authority in organisations that deliver care, including providers' board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation ensures that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role. Regulation 19 advises that persons employed must also have the qualifications, competence and skills to carry out their role.

Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check (DBS) and a full employment history).

The organisation had an employing board members policy, dated July 2015. The policy listed information required for board members including two references, professional registration, DBS check and that directors will complete an annual fit and proper person declaration document. The risk and compliance manager monitored the compliance with the requirements. The monitoring of the policy and requirements was under further development.

There were two staff who were directors or equivalent, one of whom had recently been promoted to a director from a manager's role. We reviewed both employment records. One file had all required information in except the completed fit and proper person declaration document. The file of the recently promoted director had proof of

completed DBS check, qualifications, registration and proof of identity. We highlighted this with the provider and immediately following the inspection we received proof of a reference and a signed fit and proper person declaration.

Managers had not received training in relation to leadership and management, they utilised their skills and knowledge they had developed within their career. Leadership courses had been discussed with managers and options were being explored.

Leadership, morale and staff engagement

Sickness levels were low at 1.5% from 1January 2015 to 31 December 2015. There were no vacancies within the team.

There were no bullying or harassment cases within the team. The organisation had enabled staff to have access to a whistleblowing helpline, which was available anytime. This was an external service to enable staff to raise concerns if they felt unable to raise concerns with their manager. Staff we spoke to were aware of this service.

Staff reported managers were approachable and felt able to raise concerns with them, they reported being listened to and valued.

Several staff had moved from working in the statutory sector to Care in Mind, they reported that the organisation was progressive and forward thinking. The service model allows staff to have meaningful time with young people and offer intensive and responsive interventions. Staff felt their experience of working for the organisation and support received from colleagues had enhanced their skills significantly in supporting young people with complex needs.

Staff told us that managers discussed personal and professional development within line management supervision and professional development reviews.

Managers were aware of the duty of candour and were able to give examples of occasions where this applied for medication errors within the residential services. Records showed staff had given the apology to the young person.

There had been an executive management group away day in January 2016 to discuss the organisational structure, promoting the service, commissioning and marketing. The team also used a SWOT analysis to explore the organisations strengths, weaknesses, opportunities and threats resulting in actions and timescales for future plans.

Commitment to quality improvement and innovation

Care in Mind has implemented and adapted innovative models of care and evidence based clinical interventions for use within an adolescent community setting. Structured Clinical Management (SCM) had never previously been adapted for use with adolescents, nor had a comprehensive Boundary Model, used for reflective practice with residential staff.

One of the psychologists was leading on a research proposal to Chester university for a PhD student to evaluate the model of care provided in an objective and qualitative way.

Outstanding practice and areas for improvement

Outstanding practice

A prepared letter in each young person's file with their mental health history, current challenges and how best to support them. Residential staff took the letter to accident and emergency if young people had self-harmed to the level they required hospital treatment. The letter avoided the young person having to talk through their circumstances to a variety of professionals and reduced their anxiety.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that there is a completed risk assessment in all of the files.
- The provider should ensure that physical health monitoring records are stored within the care records based at head office to ensure clinicians can review the information.
- The provider should ensure that the changes to the lone worker policy is communicated to staff and systems are in place to support the implementation of the policy.
- The provider should ensure that staff receive training on the Mental Health Act and revised code of practice.
- The provider should review the documentation provided to young people in relation to the clinical services to ensure it is accessible and meaningful for young people.
- The provider should ensure that the complaints file and log is reviewed to include the actions taken and outcome of the complaint with a reference number to identify the complaint.
- The provider should review their meetings structure to define aims and objectives of the meetings and ensure lessons learnt are shared formally with staff.
- The provider should review the leadership and management training offered to managers and directors.
- The provider should ensure they follow their policy in relation to recruiting board members and ensure all information required in relation to employing fit and proper persons is stored within employee records.